Health, Social Security and Housing Scrutiny Panel

Full Business Cases and Hospital Review

MONDAY, 12th MAY 2014

Panel:

Deputy J.A. Hilton of St. Helier (Vice-Chairman)

Deputy J.G. Reed of St. Ouen

Senator S.C. Ferguson

Witnesses:

Mr. D. Hoddinott, Deputy Director of Commissioning

Director of System Redesign and Delivery

Ms. J. Yelland, Deputy Director of Commissioning

Mr. A. Heaven, Deputy Director of Commissioning

[14:29]

Deputy J.A. Hilton of St. Helier (Vice-Chairman):

Good afternoon, and welcome to the Health, Social Security and Housing Panel Scrutiny Panel. We are here today to discuss the redesign of Health and Social Services to do with the full

business cases and the hospital review. We will start by introducing ourselves. I am Deputy Jacqui Hilton, acting chair of the panel.

Deputy J.A. Hilton:

Thank you very much indeed. I would like to start by offering the apologies of our chair, the Deputy of St. Peter, who is unwell at the present time. Also I would like to draw the public's attention to the notices on the chair, thank you. I would like to start by asking each of you in turn what particular area you have been focusing on in order to deliver the proposals that were agreed in the *Health White Paper* since October 2012. I will start with you, Derek.

Mr. D. Hoddinott:

The area is in relation to community services for adults and older adults.

Deputy J.A. Hilton:

That does not include any of the whole pathways or the children, so it is just ...

Mr. D. Hoddinott:

Children and healthy lifestyles is my colleague.

Deputy J.A. Hilton:

Okay, that is fine. So it is just adults and older adults. Can you just briefly tell us what you have been doing since October 2012 and what services have been implemented, and what ones are still outstanding?

Mr. D. Hoddinott:

Okay. It is a range of services which have been developed and implemented, so those include the carer support service, which I can go into more detail if that is helpful. As part of the long term conditions programme there has been some initial investment while we are looking at the wider whole system development of out of hospital services. The parts that have been implemented are rapid access clinics in atrial fibrillation, chest pain, and also increasing the investment in the area which was historical quite under invested which is in specialist respiratory services. Also implementing expansion of pulmonary rehabilitation.

Deputy J.A. Hilton:

Can I just stop you there? I think you just said that there has been initial investment in the rapid access clinic, can you just elaborate a little bit on that?

Mr. D. Hoddinott:

These are clinics which are instead of people needing to go into the hospital to be supported where they have early identification of problems, they can be seen in an outpatient based setting for assessment and implementation of their treatment.

Deputy J.A. Hilton:

Okay, and also with the specialist respiratory service?

Mr. D. Hoddinott:

Yes, it was an area which historically there was a very low level of specialist support for clients who had respiratory difficulties. We have expanded the number of specialist respiratory nurses who work in conjunction with primary care and other community nursing practitioners to provide support for people with respiratory conditions, including C.O.P.D. (Chronic Obstructive Pulmonary Disease).

Deputy J.A. Hilton:

Can you just explain a little bit more on how they work with G.P.s (General Practitioner) and primary care, how the services interact?

Mr. D. Hoddinott:

It varies dependent on what the individual patient needs, but if a patient is identified as having a level of complexity of their condition, a baseline support for that if that is provided through primary care. So as with most people whether they have respiratory conditions or cardiac conditions, the majority of care would be provided in primary care. However, if they have a high degree of complexity there is sometimes the need for a level of specialist input. That comes from the specialist nurses.

The Deputy of St. Ouen:

If I look at P.82 which is the Health and Social Services: *"A New Way Forward"* document, a number of areas were identified that need to be delivered between 2013 and 2015, which is under your remit, which out all of the different areas that were identified are still awaiting delivery?

Mr. D. Hoddinott:

I was concentrating initially on the question relating to respiratory. I was going to go on to the other areas.

Deputy J.A. Hilton:

All right, yes, that is fine. Is that okay?

The Deputy of St. Ouen:
Yes.

Mr. D. Hoddinott:
So on the respiratory side one of the particular areas of focus within the outline business case was looking at focusing on respiratory disease in the first instance. That was always intended to be the first priority area that we addressed. So part of that investment has been to plug the gap in terms of the availability of specialist respiratory nurses, to ensure that people who have respiratory conditions can be supported so they do not unnecessarily have to go into hospital services.

Deputy J.A. Hilton:
Did that entail you taking on additional staff?

Mr. D. Hoddinott:
There are additional staff, there is an additional 2 respiratory nurses. There has also been investment into expanding the oxygen therapy service.

Deputy J.A. Hilton:
Can I just stop you there. I am looking at the actual spend in 2013 under the title "Long term conditions" starting with C.O.P.D. and I think it outlines the conditions that you said that you are responsible for. It shows an actual spend last year of £17,500. What did you deliver for £17,500?

Mr. D. Hoddinott:
That would have been the initial level of investment that went into pulmonary rehabilitation. We started the investment in pulmonary rehabilitation in November 2013. The additional recruitment of the respiratory nurses and the additional spend in oxygen therapy has been in the early part of 2014.

Deputy J.A. Hilton:
So in 2013, cardiac services and diabetes services, was there any additional services provided under those headings?

Mr. D. Hoddinott:
Again, it is 2014 in relation to the rapid access clinics which I have mentioned, which have been in cardiac related services.

Deputy J.A. Hilton:
They are delivered at the general hospital?

Mr. D. Hoddinott:

Yes, they are based in the outpatient department.

The Deputy of St. Ouen:

I am struggling to see where in the P.82 it mentions that respiratory services should be a higher priority in 2013 to 2015.

Director of System Redesign and Delivery:

It will be called C.O.P.D. within P.82.

The Deputy of St. Ouen:

All right, but surely that is more just respiratory, is it not?

Director of System Redesign and Delivery:

C.O.P.D. is chronic obstructive pulmonary disease, so it is lung disease, which is respiratory.

Deputy J.A. Hilton:

Can I just go back to diabetes services? I mean, everybody is well aware that the incidence of diabetes is growing all the time. What has been achieved to date with diabetes services?

Mr. D. Hoddinott:

Diabetes services, there has not been additional investment, although it is part of business as usual development, there has been an additional diabetes nurse that has been recruited within Peter Bates' team to enhance that service. But that has been part of the expansion of business as usual.

Deputy J.A. Hilton:

So there has been no additional investment in that?

Mr. D. Hoddinott:

No.

Deputy J.A. Hilton:

But surely there should have been?

Mr. D. Hoddinott:

No, the focus in the period into 2015 was respiratory, albeit referred to as C.O.P.D.

Deputy J.A. Hilton:

I am just curious as to why it appears in the 2013 to 2015 breakdown in growth. So you are saying it was not ever to be delivered in 2013 or 2014?

Mr. D. Hoddinott:

No.

Deputy J.A. Hilton:

When is it going to be delivered?

Mr. D. Hoddinott:

The plan in relation to long term conditions was a roll out programme which envisaged that diabetes would come in as part of the 2016, so in the next phase.

Deputy J.A. Hilton:

Okay, so that is just a typographical error, is it? Because it has got diabetes services there but we have been ...

Mr. D. Hoddinott:

I do not know what you are referring to.

Deputy J.A. Hilton:

Okay, well, we asked Treasury to provide us with an outline of what the spend had been and where it had been spent, and under long term conditions starting with C.O.P.D. it lists pulmonary rehab, smoker cessation, respiratory services, priority investment, cardiac services, and diabetes services. So I just assumed when I saw that, dated 2013 to 2015, that diabetes services was a service that was going to get additional investment.

Director of System Redesign and Delivery:

We will check on those figures and come back to you on that.

Deputy J.A. Hilton:

Will you, because I expected to see it there because I knew it was in the *Health White Paper* as well, so we need to try and understand what has happened there.

The Deputy of St. Ouen:

What about dementia?

Mr. D. Hoddinott:

If I can go on beyond respiratory I can cover the other areas.

Deputy J.A. Hilton:

Okay.

Mr. D. Hoddinott:

So we have then got what is wrapped up as part of a broad range of services around older adults, community mental health services. For that we have developed and we are now in implementation of 3 elements to that, one of which is the mental health liaison service. The second is the community mental health team and the third is the memory assessment and early diagnosis services. All of those investments have been signed off and we are in the implementation at the moment.

Senator S.C. Ferguson:

Are you also responsible for the revision of the mental health law?

Mr. D. Hoddinott:

Mental health review, no, it is not part of my remit.

Deputy J.A. Hilton:

Can I just go back to the older person's mental health. I note that we have been told that the actual spend last year was £278,500 roughly, but did you just say that those 3 services were being rolled out this year?

Mr. D. Hoddinott:

That is correct, although we had a range of pilots that were undertaken in 2012/2013 and one of which was in relation to dementia services.

Deputy J.A. Hilton:

Okay, so this figure of £278,500, was that to do with the care and support that you implemented?

Mr. D. Hoddinott:

That will be dementia respite but, as I say, the figures ... I have not seen what you have in front of you.

Deputy J.A. Hilton:

But as far as dementia respite went, was that service rolled out as a pilot last year?

Mr. D. Hoddinott:
Correct.

Deputy J.A. Hilton:
So it was rolled out as a pilot last year, what is happening this year and the following years?

Mr. D. Hoddinott:
It has been included within the overall implementation plans for those services. So we have learned from the pilots and those have informed the implementation planning for the new services.

Deputy J.A. Hilton:
So the families that were accessing dementia respite in 2012 and 2013, what is happening to them now in 2014?

Mr. D. Hoddinott:
It is continuing.

Deputy J.A. Hilton:
So families who were getting the service are still getting the service?

Mr. D. Hoddinott:
Correct.

Senator S.C. Ferguson:
I was just wondering, we have talked about 3 problems here, the respiratory one, C.O.P.D., the diabetic, and the dementia, what is the scale of the 3 problems? Roughly how many patients do you reckon we have in each of those categories?

Mr. D. Hoddinott:
I was not aware those would be detailed questions, if I had have done I would have brought along some information with me. So I would need to come back to you with any points of detail.

Senator S.C. Ferguson:
I was just wondering how you prioritise the 3 areas. I mean, if you have an anti-smoking campaign then obviously you are going to do C.O.P.D. because one follows the other, usually.

Director of System Redesign and Delivery:

Back in 2010 when we started the strategic work that preceded the White Paper you will probably recall KPMG did quite a lot of work benchmarking analysis, lots of stakeholders, lots of the clinicians and social workers who work in the system at the moment ...

Senator S.C. Ferguson:

Yes, I am just asking what the scale of the problem is now. Derek has said that he will bring the figures back, that is fine. Thank you very much. Sorry, there is so much else to go through that I do not want to ...

Director of System Redesign and Delivery:

Yes, well, the numbers are in the outline business cases which we will resend to you after this meeting.

The Deputy of St. Ouen:

Can you just tell us a little bit about what is happening with the active ageing and wellbeing centre?

Mr. D. Hoddinott:

Okay, the active ageing and wellbeing centre, that was developed and they changed the name to community resource centre, and we have subsequently worked in conjunction with the voluntary and community sector partnership group to look at how we might be able to support the development of that during this year. The outline proposal that has come forward, which we are still in discussion about, is working in partnership with the Salvation Army who have an existing property that could very usefully be used to provide the purpose that we intended from that centre, which is provide a range of multi suite rooms which are accessible for voluntary and community sector organisations to use to support our clients.

The Deputy of St. Ouen:

Also, can you tell us about end of life care?

Mr. D. Hoddinott:

I can do indeed. The end of life care work, we have taken that through a process where we ended up with a partnership formed between Jersey Hospice Care who are the natural leaders of provision of specialist palliative care on-Island, the primary care body, and Family Nursing and Homecare are the core providers of support. Hospice are in the lead and we are in the closing stage of finalising an agreement with Jersey Hospice Care to enable them to provide support to Islanders for all palliative care needs.

Senator S.C. Ferguson:

You are not using the Liverpool Care Pathway any more?

Mr. D. Hoddinott:

Liverpool Care Pathway does not exist as far as Jersey is concerned, or indeed the U.K. (United Kingdom).

The Deputy of St. Ouen:

How confident are you then that in the areas that you are responsible for that the full business cases that fall under your remit will be delivered?

[14:45]

Mr. D. Hoddinott:

If I could complete the final ... there are some additional areas if you wanted me to cover the other parts. The other part is Jersey Talking Therapies which we have previously discussed in previous scrutiny meetings. Again, that is implementation phase and we expect to be at full capacity of that service around about September of this year, which was the original envisaged timescale. We are in the recruitment phase at the moment. So in terms of level of confidence that we have made very good progress and, as with most things over a period of a couple of years, things have moved and looked at change as we sort of build on the basis of the most recent evidence. So part of what we are doing now is to look at the development work we have undertaken and look at it in a whole systems context of all out of hospital services, how that operates to provide the best services at the most appropriate time for Islanders. So things are moving. In terms of what we originally set out to do I think we have made very good progress on that. I have confidence we have fulfilled that in terms of ... you phrased it as the full business case but in terms of the phase one transition plan and the work that we are undertaking to look at it in the whole system context, we will have got to a stage of having clarity around that implementation by the end of this year also.

Senator S.C. Ferguson:

I am sorry to go back to this again, can you just confirm absolutely categorically that we are not implementing or using the Liverpool Care Pathway any more? It was being used at one stage.

Mr. D. Hoddinott:

For the avoidance of doubt, we are not implementing the Liverpool Care Pathway.

Senator S.C. Ferguson:

Thank you.

Deputy J.A. Hilton:

Can I just take you back to the diabetes because I have just had a look in the annex to the Medium Term Financial Plan ...

Senator S.C. Ferguson:

Or anything similar?

Mr. D. Hoddinott:

We are not implementing the Liverpool Care Pathway on the basis ...

Senator S.C. Ferguson:

Or anything similar?

Mr. D. Hoddinott:

It is not a re-badge, we are not doing a re-badge of the Liverpool Care Pathway so ...

Senator S.C. Ferguson:

No, but there was quite a kerfuffle when the Minister admitted that it was being followed, and obviously the public were really quite upset about it.

Mr. D. Hoddinott:

What we are doing, as we are doing for a number of areas of services provided to Islanders, is to operate person centred care planning, not the Liverpool Care Pathway which is fundamentally different.

The Deputy of St. Ouen:

You did say that things are moving, changing, as you look forward. Has there been a reprioritisation in some of the services that were originally identified to be delivered within your remit over the 10 year period?

Mr. D. Hoddinott:

No, there has not been a reprioritisation. We are still working on the lines or the priorities that were set out within P.82.

The Deputy of St. Ouen:

So everything that was agreed and approved within P.82, the States Members and the public can expect that in the years that they have identified that these improvements should take place, they will be able to see the new services come online?

Mr. D. Hoddinott:

Correct.

The Deputy of St. Ouen:

What discussion have you had with users and the general public about the delivery and performance of the new services that you are telling us have now been introduced?

Mr. D. Hoddinott:

As part of the development of the White Paper a significant level of public consultation took place.

The Deputy of St. Ouen:

Sorry to butt in, but I know consultation happened in the White Paper and we have reviewed that already, what it does say though is that with regards to commissioning it sets out what is expected from the commissioning process. It is that particular area that I would like to understand better.

Mr. D. Hoddinott:

Okay. As part of implementation planning, when you get down to the detail about how a service will be delivered it is at that stage that you have the involvement of service users, and indeed there are sometimes advocates on behalf of service users in terms of the detail planning. That is not just for the White Paper, that also goes across all aspects of services. For example, we are currently going through a few processes at the moment we are selecting new providers and we have service user representatives on the panels that are helping us select those service providers.

The Deputy of St. Ouen:

Are you putting in place appropriate outcomes that are able to be monitored to ensure that the improvements are indeed as they say they are?

Mr. D. Hoddinott:

Absolutely. That is a critical part of ensuring that we are demonstrating that we are achieving value for money, outcome is one aspect of how we ensure that what we have bought is delivering benefit for Islanders. For each of the service areas we have got clear measures which we set and that measures a number of things. It measures how much activity is being undertaken, it also measures the efficiency in which that activity is being delivered in terms of services being

delivered in a timely fashion. It also measures the outcomes that are achieved, in other words the impact that it has on Islanders.

The Deputy of St. Ouen:

So when are you planning to first report some of these outcomes?

Mr. D. Hoddinott:

Services have to be operational before we can report outcomes so, for example, the carer support service, that has been delivered through a partnership led by the Citizens' Advice Bureau and so I have metrics in terms of what we are achieving for Islanders with that service. I have the same with pulmonary rehabilitation, both in terms of the impact it has on reducing the waiting list, the impact it has on enabling people to perform activities of daily living without suffering breathlessness. So there are a number of areas where individual services that we already have in place are established and running, then I am getting the first reports from that and I review those outcomes in conjunction with providers of the service. I also get information back from service users in terms of their experience in using those services, so that we can use those to inform how the service continues thereafter.

The Deputy of St. Ouen:

How many of the new services that you are responsible for have already been implemented and up and running, and how many are still to be implemented?

Mr. D. Hoddinott:

At the moment we are in implementation for Jersey Talking Therapies, the older adults' mental service. As just indicated, we are at the early stage of some of the long term conditions area of investment so we are starting to get some information through on that. Pulmonary rehabilitation, which is the longest standing of that, I have sufficiently reliable data that I have confidence in terms of that delivering what we wrote on the tin. So we have quite an area of work where we are now - for example on the talking therapies - where the service will be starting to become available from next month and then will build on a gradual basis through to September when it will be fully operational. So I will not have any data on that at the moment but come September I will have the outcome of that first quarter of partial implementation where we can have some confidence. I will be reviewing that on a very regular basis, supported through a steering group that we have established which includes input from the voluntary community sector and the primary care body to ensure that we all have the same level of confidence about how that service is evolving and delivering.

The Deputy of St. Ouen:

In your opinion, when it comes to the commissioning of new services, would you expect it to take almost 2 years from start to finish, or would you anticipate an earlier lead in time?

Mr. D. Hoddinott:

It depends on what service. Some services are relatively ...

The Deputy of St. Ouen:

The services you have been telling us you will deliver.

Mr. D. Hoddinott:

There is quite a wide portfolio that I have described that falls under my area of responsibility. Some of those services are easier than others and those are the ones that we have implementation on at an earlier date. Others have been more complex because they deal with services which have not previously existed, and there are some quite important partnerships that need to be firmly in place to ensure that they are going to be successful. I am not trying to avoid giving you a straightforward answer but it does vary depending on the complexity of the service and indeed the complexity of some of the relationships that are required to deliver it.

The Deputy of St. Ouen:

Finally, looking ahead to the future, we know that there are 3 delivery phases to the overall transition programme. Would you expect a shorter time from start to finish for the second and third phase of development than you have seen in the first?

Mr. D. Hoddinott:

Because we have a lot of the building blocks in place with the first phase, we have established some of the important relationships, we have a better awareness from - I use the general term - the market as to what we are seeking to achieve. So I would expect things to be faster or shorter in the next phase.

Deputy J.A. Hilton:

Just before we leave you, Derek, I just want to try and understand why diabetes is mentioned in the *Health White Paper* P.82 which the States agreed in 2012, it is mentioned in the figures that we have confirmed from the Treasury Department, and it is also mentioned in the Medium Term Financial Plan 2013 to 2015. I think you have said that there has been no additional services for diabetes and I am just wondering why when it has been talked about in all these documents I have in front of me. Have you any idea?

Mr. D. Hoddinott:
The period up to 2015 was focused on respiratory disease.

Deputy J.A. Hilton:
So are you confirming that diabetes will be looked at in that period ...

Mr. D. Hoddinott:
Absolutely.

Deputy J.A. Hilton:
All right, thank you, we will move on. Rachel, we know that you are responsible for the redesign and delivery. Do you mind if we move on to Jo, because of time, and then we will come back to you?

Director of System Redesign and Delivery:
That is fine.

Deputy J.A. Hilton:
We will move to Jo. If we can ask you the same thing, Jo, when did you first become involved in the delivery of the *Health White Paper* reforms, what you have been doing, what you have achieved and what you are going on to do.

Ms. J. Yelland:
Well, I first started in January 2013 and my role is somewhat different in that a significant part of my role is not focused on the White Paper. So a significant part of my role is focused on our contracting services off-Island, so that means the services that we buy from hospitals on the mainland for population, but also individual packages of care that we need to buy for adults and children from the U.K. and elsewhere. So a big part of my role is not directly connected with the White Paper. In terms of the White Paper, probably because of that and the fact that I was the last in the team to arrive, my sort of focus was really a bit about internal challenge, so it was really about looking to see how well we are doing. So Rachel asked me to sort of focus particularly on engagement, so some of the issues around building the partnerships to make some of these happen that Derek has just been describing, was really to take a look to see what were the things that were working really well with that engagement and what things we could have done better. So I did an initial piece of work working with sort of key stakeholders, not with service users at this point but really with the various organisations, clinicians and so on, all the people with a vested interest to see why we were moving forward quite quickly on some things and stumbling to get agreement on some others. So that was the initial sort of 3 month focus of my contribution. From

that process we reflected on the things that had gone really well and then have built in more of those things into how we move forward. That reflection has helped to sort of shape how we work together and some of those relationships. I moved us on out from some quite difficult areas where there was not necessarily a common view, which why would there be if there are so many different stakeholders with individual views and concerns. So that was a big sort of focus initially and then from that as the future hospital plans are emerging, and as those strategies are being developed, I am sort of, if you like, the person on the shoulder saying: "What is that going to mean to the rest of the system?" and to start making sure that as those concepts are unfolding at obviously high level, that we are connecting it back to the reality of the whole system. So, if you like, I am sort of there as a reminder really about the fact that it is a whole system and that you can do something over here with all the right intentions, but if you are not carefully thinking about the impact of it over here you could accidentally have unintended consequences. So I am the sort of genie on the shoulder annoying people really, saying: "But have you thought about ..." and then getting in discussions with people about how we might mitigate some of those risks and think about how we plan them in. So you will know that I have come back and talked to you before about where our thinking has shifted around the out of hospital piece. So where Derek has described lots of different initiatives that have been piloted and the various stages of that, it is saying that how do we take the learning from all those different pilots and saying what are the things that we could take from the different pilots and build as principles for our whole system? So, your question is really interesting about how do we prioritise so from dementia, to C.O.P.D., to diabetes?

[15:00]

Well, people do not come in neat packages, do they? Because you will find a lot of people will have diabetes, dementia, C.O.P.D. and they might also fall over or have an accident and need services. So, it is really about moving away from thinking in service terms to thinking more in whole-system, and as Derek described in response to the question around the Liverpool Care Pathway issue, they are actually trying to move people's thinking to personalised care-planning, that is based on the needs of the person, irrespective of the diagnosis or the labels that we might have traditionally put on them. So, my role really has been about having those conversations with people and getting people to start thinking culturally quite differently about how we deliver services absolutely in line with the vision set out in the White Paper, absolutely in line with those objectives but helping them to think more in whole-system terms. As we move forward into phase 2, I think that we will see implementation move quicker because we will be moving into more whole-system implementation, as we have learned how to implement new and different things in different service lines.

The Deputy of St. Ouen:

Can I ask … you said that you have been, since January 2013, tasked with looking at off-Island arrangements? That, and you said it was, was true. Did it include all off-Island arrangements?

Ms. J. Yelland:

Yes.

The Deputy of St. Ouen:

Has that work been completed?

Ms. J. Yelland:

Well, no. It is business as usual. It is ongoing. So, just to give you some examples about things we have achieved ... and remember one of the key things for us is that we need to keep a very careful eye on what is happening, particularly in the NHS (National Health Service) because we are on the coattails of N.H.S. system change. That has been one of the things that would have been quite a risk to us as an Island community who are not part of the N.H.S. We may have found it more difficult to get the support from the N.H.S. that we need had my kind of role not been here. So having someone who ... my job is to build relationships with those U.K. providers and make sure that when we want them to provide services for Islanders, that they treat Islanders in the way we would like them too, and that they are not in any way regarded as a second-class citizen because we do not have the levers that the N.H.S. has with hospitals to make them see patients in a certain way. So, what I have been doing is negotiating good relationships with the key providers that we use, to make sure that Jersey patients get the best that we can. So, one of the areas we focused in on early last year was cardiology. So it is the area in terms of acute medical care, that we spend the most money on off-Island for obvious reasons because of the complexity of the services. We tendered for those services in a different way, and as a result we awarded a contract with a provider and we now send more people; we send them much quicker, so people wait less to get to the U.K.; they spend less time in hospital beds, and we believe that the outcomes we are getting from that are better than they were before; and we also know that we are doing that and spending less money. So, more people are getting seen, getting the treatment they need. Right time, right place, good outcomes and it is costing us less, because we went through a process of tendering and making the N.H.S. work with us on our terms, rather than us having to work on their terms.

Senator S.C. Ferguson:

Do you also take advantage of the fact that some of the consultants we have over here, in fact have very good relationships, for instance, in cardio and therefore we get good treatment anyway?

Ms. J. Yelland:

Yes, we exploited that to the maximum and the example with cardiology is that I worked really closely with Andrew Mitchell, our on-Island consultant. One of the evaluation criteria that we have is ... well, there are 2 that are relevant. One is added value, so asking the U.K., or other - could be from anywhere - providers what are they going to do for us that gives us added value? That has been a way of testing out how much they value our business, and we got a considerable amount of added value by me working with Andrew and with the clinicians from the U.K. providers. So, for example it means that for cardiology we get free transport for our patients. So when our patients arrive on the U.K. mainland, they get collected by Mike, the taxi driver who picks them up from the airport and takes them to the Oxford Radcliffe Hospital, and we do not pay for that. The bill goes to Oxford Radcliffe so we know that it is cheaper for Jersey but also the feedback that we get from our patients is that it is really nice to have a friendly face. Often these are people who are going more than once and knowing that someone is going to pick them up, take them to the hospital and bring them back, saves a lot of stress and anxiety for people, obviously. So there is that element of it, but what we also have ... in the past we used to have to do a lot of work to find locum consultants who would cover for Andy Mitchell, for example, when he was going on holiday, because he is a single-handed consultant here. What happens now is that an existing member of the team at the Oxford Radcliffe will come and do his job plan when he goes on holiday, and we have built that into our contract. So, we no longer have the pressure and the cost of having to try to find a locum, and also the worry of knowing whether or not they are going to be of the right quality. What happens now is that the locum will be somebody who is also part of the team in Oxford, so for our patients there is continuity of care. So, effectively it is their patient and that works brilliantly.

The Deputy of St. Ouen:

Very simply … I mean, it is great to hear and it is good the success you have had. We really would like to understand how long it would take you to complete a review of all of the off-Island services so we could see the benefit right across the health service rather than just on one area?

Ms. J. Yelland:

Yes, absolutely. There are documents that set out some of that and at the moment we have got a work programme for this year where we are focusing in on 4 areas, and 2 of those are underway this week. We are interviewing potential providers and another 2 are under development and will be going out to tender for a really exciting development, that is Urology and Renal combined - cradle to grave services. At the moment if you have a kidney problem or a liver problem you might go to one of 20 different providers in the U.K., and I am working with the consultants, with the help of some of our new appointments this year, who have got some really great ideas about how we could make that better for people. So, we are working together with paediatrics, obstetrics and

gynaecology, and our renal and urology consultants to have a joint specification, and that will be going out to tender probably at the end of June, early July.

The Deputy of St. Ouen:

Is there an overall programme outlining the time to review all of the ...

Ms. J. Yelland:

Yes, there is.

The Deputy of St. Ouen:

That would be great if you could provide it to us. I suppose leading on from that, you mentioned the hospital. One of the areas that we would like to better understand is what consideration, if any, has been given to what services should be provided on-Island, off-Island and what criteria perhaps, have been used to determine the services that should be provided on-Island against off-Island?

Ms. J. Yelland:

Yes, it is a chicken and egg kind of question, is it not? Because there are a number of different ways of approaching that and the way we are approaching it at the moment is by working on the acute services strategy that ... I am sure you have been talking to Bernard Place about that. So, and again part of my role will be when …

Senator S.C. Ferguson:

We are looking forward to seeing it.

Ms. J. Yelland:

Yes … is to have a look at ... and I am responding to invitations to participate in those debates, and again my challenge into that is saying: “Have you thought about whether these services could be on-Island, off-Island?” An example of that is radiology where we are doing a piece of work to look at whether or not we can repatriate all of radiology services and have those as part of the future hospital, and I have been quite instrumental in helping people think that through and what that could look like. So …

The Deputy of St. Ouen:

Who will ... going back to the acute services strategy, who will help shape, form and agree that strategy?

Ms. J. Yelland:

I think lots of different stakeholders. So initially it is internal, in the sense that it is H.S.S.D. (Health and Social Services Department) as a department looking at that, and then through the future hospital work, the technical advisers who will be recruited will put in some challenge into that, and we will challenge us as a department, and within that I am putting in my own challenge of user input, and I guess through the normal governance process so will everybody else. I think that is ... we will get to that. It is an iterative process. You have almost got to put something down and then challenge it and work that through and there will be different answers in different specialties. The other reason why I think it is really difficult - and I know it sounds like I am being evasive but I do not mean to be - it is just that the market in the U.K. is moving really fast and we are already finding that some U.K. providers do not want to continue providing services for off-Island communities - and we are not alone in that - because of the pressures that they are facing in the way that the market is changing in the U.K.. So, and also remember that the way that new technologies come into being is that you may have something - an example would be capsule endoscopy. So 10 years ago when capsule endoscopy came into the market place it could only be done in 2 or 3 places because it was highly specialised and clinicians had to develop skills. Now it is a matter of routine and we will be doing capsule endoscopy in Jersey within the next 12 months, which is fantastic. So, I think what will happen over time is that once we have got the broad strategy, with those principles that says it needs to be safe, sustainable and affordable, and we should do that on-Island where we can, and where we cannot we need to find alternative ways of doing it ... but that will always change.

The Deputy of St. Ouen:

Yes, I understand that but I am interested in what part the public are going to play in the development of this strategy, because ultimately it is the public/the taxpayer, that pays for any service that is going to be promoted.

Ms. J. Yelland:

Yes. So I think that … my understanding is that in terms of the principles of safe, sustainable and affordable, they must be the baseline by which we test all our decision-making.

The Deputy of St. Ouen:

Right.

Ms. J. Yelland:

If we come up with an Acute Service Strategy, they have got to be the key criteria. There is no point saying to the public: “Shall we do all open-heart surgery on Jersey, would you like us to do

that?", if it is not going to be safe to do that, or sustainable, or affordable. So I think we have to have an intelligent debate based on some principles that we apply right across the board.

The Deputy of St. Ouen:

Right, so when do you see that debate happening?

Ms. J. Yelland:

Well, as far as I know it is part of the plan. I am not into the detail of the plan, the project plan, that Bernard's got going.

The Deputy of St. Ouen:

Right, so you are not involved in this communication or representation they are making?

Ms. J. Yelland:

No, because that fits in with Bernard Place's remit, but I certainly am involved in that. I will be putting my comments in alongside everybody else.

The Deputy of St. Ouen:

So the determination of what services should be provided on-Island, off-Island are forming part of the development of the acute services strategy?

Ms. J. Yelland:

Yes.

The Deputy of St. Ouen:

Presumably, once that has been agreed, then we will have more certainty about what size of hospital we need?

Ms. J. Yelland:

Yes ... well, I do not know that it will necessarily depend on that. You have got to look at it on 2 levels. One is we have a population of a certain size and like everywhere else we have got an ageing population, and the work has already been set out in the strategic outline case that says, on the basis of this population with these kind of needs, we are going to need a hospital that is X size; and this is about the detail, the fine detail, of the types of services that will be provided in that. So, even if you think about what we do with cardiology, for example, now. How I would imagine that would look in the future is that we will still always need to have some procedures done in the U.K. because there are procedures in the testing now, that are not currently offered in the N.H.S. but in 3 years' time they will be, and those treatments are not currently available to anybody. So,

we might move some things that currently get done in Oxford, we might be able to do here but there will be new treatments and new developments that we cannot even imagine now that are going to be available in 3 years' time. So there is going to be a constant movement of different detail.

The Deputy of St. Ouen:

As you said … I mean, I suppose it would be interesting to know what principle sits under each of the criteria. Safe, for instance, with 100,000 population you are not going to bring top, first-class specialist consultants.

Ms. J. Yelland:

Why not?

The Deputy of St. Ouen:

Well, you have to ask them but I am sure if you sent out a questionnaire to all the consultants that are in the leading specialist hospitals supported by universities in the U.K., they will give you good reasons why they would not think about coming here.

Ms. J. Yelland:

So, if I give you … it is a good way to give you an example about how my job works. So, I have been talking to some of those hospitals about exactly that. I am going to see hospitals and find out which hospitals are interested in having the work from Jersey to help them sustain some of their services.

The Deputy of St. Ouen:

Right.

Ms. J. Yelland:

So hospitals, if you think about hospitals in the south of England, are losing some of their specialties because they are struggling with numbers. So it might be, say, that you have got to have each consultant in your team has to do 100 of those to keep up their accreditation. Now, they might have 80 and they are looking around to see where are we going to find another 20? Now, I might be able to come along and say: "Do you know what? I have 10 in Jersey." I cannot give too much away because it would be prejudicial to some of the commercial stuff I am working on, but there are some organisations who are saying: "Well, as you move forward with your Acute Services Strategy, we could be a partner in that specialty and we could include your staff as part of a wider clinical network with our staff, and we could do those procedures in your lovely facility, because you will have modern facilities that our staff will be able to work in. So, you do not need

to send your patients to us. We will come to you." There is huge potential for us to do that. So my role is to keep a watchful eye on where we are going and keep the conversations going with some U.K. providers who, I think, will be interested in forming strategic alliances with us once we are clear about where we are going. So it is part of … again, as Derek was saying, but a lot of what we do is a bit soft, in that it is relationship building and creating opportunities and giving ideas to people about how we can work. So …

[15:15]

Deputy J.A. Hilton:
So, you think that is a definite possibility in the future?

Ms. J. Yelland:
I think it is an absolute possibility. Absolutely.

Deputy J.A. Hilton:
Jo, can you just … I believe that your job description has changed recently?

Ms. J. Yelland:
Yes.

Deputy J.A. Hilton:
Could you just give us an update on where you are with the new primary care model?

Ms. J. Yelland:
Yes, that is right. Very recently, a few weeks ago, my role has extended to take on the sustainable primary care.

Deputy J.A. Hilton:
Are you still involved in doing the acute work plus the primary care work?

Ms. J. Yelland:
Yes.

Deputy J.A. Hilton:
Have you been given any additional staffing to …

Ms. J. Yelland:

They are on their way. Thank you.

Deputy J.A. Hilton:

Right. Well, we did not want to think that the acute work was going to slip, which is really important because you are under pressure to deliver this new model of primary care.

Ms. J. Yelland:

Absolutely. Yes, thank you. So, yes, we have got to the stage where we have now got a formal board in place, a programme board. That has had its first meeting and we have agreed terms of reference.

Deputy J.A. Hilton:

Can you just tell us who the board is made up of?

Ms. J. Yelland:

Yes. Have to remember that now off the top of my head. The board is made up of representatives from each of the key primary care professions, so the doctors, the dentists, the pharmacists and the opticians. We also have representation from the Treasury, from Social Security, from H.S.S.D. We have got representation from the voluntary and community sector and also from community nursing. All the governance arrangements around that and how we are going to operate and how decisions will be made, et cetera, have all been agreed and negotiated, so we have got the first hurdle overcome. What we are working on at the moment, and I can send you this, I can email it to you if you want to see it, is it is a draft paper that the board is going to consider at its next meeting, and I think it is the 23rd of this month.

Deputy J.A. Hilton:

We would be really interested to see that if you send that through.

Ms. J. Yelland:

Yes, and this is really where we think we will be in terms of identifying what is the scope of primary care, because everyone uses the words primary care and there are lots of different ways of defining what that means. So in England, for example, primary care are the services provided by doctors, dentists, pharmacists, opticians. Other people define primary care as services that can be provided by any type of professional, but they are meeting the primary health needs of the population. So there are different ways of looking at it and we are going to have some workshops of the project board in June to define some of those things. So what we will bring through the governance process by September-time is hopefully areas where the group are agreeing on what

is the scope of primary care, how we are defining it, what are the principles that everyone is agreed on so that we can isolate the things that are going to be problematic for us in terms of things that we do not know enough about to get a consensus. We can focus on those things, but give clarity to some of the things that everybody is agreed on. Examples of that would be, do we want to incentivise people to take part in primary prevention, as an example? Would we want that to be in our system? So, we can have a number of statements that we can say, these are clear principles that we would, as an Island, want to support.

Senator S.C. Ferguson:

It is a private cost and a public saving. The economists denote it when you have, for instance, an anti-smoking campaign, because smoking is a private cost but it is a public saving, so yes.

Ms. J. Yelland:

Yes, so none of these ... these are principles, are they not? You are absolutely right to point that out. I am just giving that as an example. So another principle might be, in Jersey do we want our primary healthcare system to have a co-payment issue attached to it? Do we want to have some people exempted from that and if so, which types of people in the population? So would we want people under the age of 5 to be exempted, or do we want people over ... you know, all those things? I do not know the answer to that, but the process that we have agreed through the steering group, is to have those discussions and then identify where do we have agreement about which things should be there, and what are the things that we need much more debate about because there is less agreement?

Senator S.C. Ferguson:

When are you going to have the public consultation?

Ms. J. Yelland:

When we have something to consult with the public about. That is what I mean around getting something that we can have an intelligent discussion around, which we hope will happen September, October time, and then depending on the outcome of that discussion and work where the governance process takes us, we may then be in a position to be having something material to consult with the public early in the new year.

The Deputy of St. Ouen:

What is the reason behind why it has taken 18 months or more to get to a point of simply agreeing a definition of what primary care should be or is?

Ms. J. Yelland:

If I could answer that I would be brokering international peace talks. I think the serious element to that is all this is really complex, is it not? You know, the whole ... perhaps I should not say it, but I will, is that, you know, I still feel that I am a relative newcomer here and I sometimes do not think that people really grasp the enormity of the change programme that the department and the States have set. You know, communicating and getting everybody in the same place at the same time, understanding, you know: "What is in it for me?" because essentially that is what everybody does, is it not? It is human nature. We all want to know how it is going to benefit us. Why should we participate? That just takes a long time and it is really easy to assume that people are on board and people understand what is required, and we use the words really carelessly a lot of the time, which is why I want this to go back and I want that group in particular to go back to the basics and define what they mean by primary care.

Senator S.C. Ferguson:

Do you not think, perhaps, that you need to go back to the basics and talk about a sustainable funding stream?

Ms. J. Yelland:

Absolutely, and that is part …

Senator S.C. Ferguson:

That comes first?

Ms. J. Yelland:

Well, unless you know what it is that you want to fund, how do you know what sustainable means? You have got to define your options, have you not? You have got to set out what it is you want to pay for? What are our options, what are our choices? Once you know what those things are - there will be certain things that everybody will say: "We absolutely must do that", so we know it has got to be in, and then there are things where different constituents think: "Well, I am not so sure if we should have free primary care for people aged over 85." Some people might say yes, some people might say no. So, okay, we have got to do more work in finding out people's views about that. This is really trying to break it down into what I call bite-sized chunks. It is a great big elephant and we have been trying to eat it all at once. So, I think, let us break it down into the bits. Work out what we can agree on, because there is lots, I believe there will be lots that people can agree on. What happens is we get focused on the things like: "How much am I going to get for this?" because people are worried, understandably.

Senator S.C. Ferguson:

Yes.

Ms. J. Yelland:

So I think we have got to build some confidence and it is back to that whole relationship stuff. We have got to build relationships. I remember when I first came here, which was 3 days into my job last year, where people were very suspicious. If you remember that debate where we had the doctor sitting here saying commissioning is a load of rubbish? Then we have all moved on because we have built relationships and we have shared our knowledge and experience, and people have shared their knowledge and experience with us, and we have all shifted and moved our positions. This is no different. It takes time.

The Deputy of St. Ouen:

There are a lot of issues and indirect links with the development of primary care, the development of the out-of-hospital services, and what is provided within a new hospital.

Ms. J. Yelland:

Yes.

The Deputy of St. Ouen:

Given the delay, and quite naturally ... I think you quite rightly said that we underestimated the enormity of the job. Given that the delay dealing with some of these methods, what impact do you see that having on gaining some form of decision around the shape and size of the hospital?

Ms. J. Yelland:

I do not think at this stage it is fundamentally a difficulty. As I said before, where the planning is, it is the population level planning and those things will not change. I think as we get into the next phase, where you are looking at exactly what is provided within the hospital and how it is staffed, and what the care pathways are for people, and indeed whether some of the staff in the hospital are providing services outside of that building base, and I think that is when we would be in a real problem if we had not got the primary care stuff sorted out. In terms of where we are now - so it we are not able as an Island to have a view, probably about this time next year, and agreement about sustainable primary care strategy or be well on the way to doing that, then I think we would have a big problem. Because I think you would be looking at a hospital that would need to be bigger.

The Deputy of St. Ouen:

It is probably not a question that you are able to answer, but I am also aware that currently work is going on apace now in relation to the next Medium Term Financial Plan and if you are unable - not you - if we are unable to gain agreement on sustainable funding mechanisms for health and social care or primary care, I just wonder how we are going to provide appropriately, and fund appropriately the services and other matters that are naturally going to flow from that work?

Ms. J. Yelland:

Yes. It is a worry that I would share.

Deputy J.A. Hilton:

Okay, thank you. Andrew.

Mr. A. Heaven:

Are we out of time?

Deputy J.A. Hilton:

No. **[Laughter]** No, we are scheduled until 4.00 p.m.

Mr. A. Heaven:

Are we?

Deputy J.A. Hilton:

If we run over slightly, that is all right, is it not?

Mr. A. Heaven:

Yes, I have a note.

Deputy J.A. Hilton:

Right, if you could just explain to us exactly what you do and what you have been doing since October 2012, which services you been involved in?

Mr. A. Heaven:

Okay, so I have been involved with this process from the start really, because I used to work in public health and was seconded across as part of the O.B.C. (Outline Business Case) writing, and the 2 areas which I have been involved with as part of the transition plan have been children and healthy lifestyles.

Deputy J.A. Hilton:
Okay.

Mr. A. Heaven:
All right? So what that translates into in terms of healthy lifestyles, that is all the work around alcohol.

Deputy J.A. Hilton:
Okay. Can we start with Children's Service?

Mr. A. Heaven:
Yes.

Deputy J.A. Hilton:
I see that some additional funding was given to Children's Services because of pressures this year. Was that to do with lack of specialist foster carers?

Mr. A. Heaven:
Not specifically, no. I think that was to do with their business-as-usual, in terms of the pressures of their work. We did put across some ... we have moved some monies into specialist fostering as you made reference to the outlined business case, and some of the indicative funding in there. Originally in specialist fostering you had 2 lumps of funding. The first lot of funding was in the M.T.F.P. (Medium Term Financial Plan) phase 1, and the second lot was in M.T.F.P. phase 2, and effectively what we did was move some of that funding forward, and so we pump-primed it, if you like. Because what we realised was that in the work that went on subsequent to the outline business case, we found a different way of delivering specialist fostering.

Deputy J.A. Hilton:
Okay. I have got here 2013 actual spend across the whole of the Early Intervention Children's Service.

Mr. A. Heaven:
It is probably more than it originally was.

Deputy J.A. Hilton:
Yes. Well, it says £359,000. Does that sound about right to you?

Mr. A. Heaven:
Roughly.

Deputy J.A. Hilton:
Yes, and a spend to the end of the first quarter of 2014 of £91,392. So, can you just explain to us where you are with specialist fostering? How much have you managed to roll out of that service?

Mr. A. Heaven:
Okay. So, the specialist fostering was a service pack that was agreed - one of the earliest service packs that were agreed and signed off - and delivering that service are our own Children's Services. They have been involved in working up the policy framework to allow the enablement and training of our own fostering workforce. Originally the specialist fostering was costed on a ... literally by making them part of our own staff, so hence there was a bigger cost. Whereas, the model where we ended up was that they would have a contract for service essentially, and we would train them up according to the National Standards for specialist foster carers.

The Deputy of St. Ouen:
So, hang on. Just to be clear, the people who are currently providing professional specialist fostering are paid employees of the health service?

Mr. A. Heaven:
No.

The Deputy of St. Ouen:
No?

Mr. A. Heaven:
No. Two things: we do not provide specialist fostering here in Jersey at the moment, so the aspiration caught up in the O.B.C. work was to do that.

Deputy J.A. Hilton:
Yes. So what has happened instead?

Mr. A. Heaven:
Originally in the way that it was put forward in the O.B.C. to achieve that, was to effectively …

The Deputy of St. Ouen:
Pay people to look after their children.

Mr. A. Heaven:
But as part of Health and Social Service, so make them part of States …

Deputy J.A. Hilton:
Okay.

Mr. A. Heaven:
Not make them but, you know, contract them in.

Deputy J.A. Hilton:
Yes.

Mr. A. Heaven:
Essentially where we ended up, following the Task and Finish groups who, when we looked at it in more detail, and we looked at how other areas - so local authorities in England - were working, it was much more of a contractual agreement which was a different way of funding and had a different … You know, it was a different way of doing it and we went with that.

[15:30]

The Deputy of St. Ouen:
Okay, contractual agreements with who?

Mr. A. Heaven:
So say us 3 are part of the fostering team, yes? We are social workers.

The Deputy of St. Ouen:
Right.

Mr. A. Heaven:
The original way that was looked at in the outline business case was to bring all of the specialist fosterers and employ them as part of that department, yes?

Senator S.C. Ferguson:
Foster parents?

Mr. A. Heaven:
Yes.

Senator S.C. Ferguson:
Right, okay.

Mr. A. Heaven:
Whereas, where we ended up following discussions was not that they became part of the department, is that we contracted ... they had a contractual agreement in the way that they do not have at the moment.

Deputy J.A. Hilton:
So you basically have a service level agreement with foster … something like that?

Mr. A. Heaven:
Something of that ilk, yes.

Deputy J.A. Hilton:
Okay, so how many additional specialist foster carers have you managed to set on?

Mr. A. Heaven:
At the moment ... so in the Task and Finish group we spent a lot of time working out, well how many do we need? Where we got to was that ... what was important was the discussion covered not only, in order to answer the question of how many specialist fosterers do we need, we needed to also understand how many other types of foster carers we need too. If you think about it in terms of a triangle, with specialist fostering at the tip of the triangle.

Deputy J.A. Hilton:
I thought the specialist foster carers were for those children with very challenging behaviour?

Mr. A. Heaven:
Correct.

Deputy J.A. Hilton:
But not all children have got challenging behaviour who come into foster care, do they?

Mr. A. Heaven:
You want to come around my house? No, you are quite right but what is important, okay, is the specialist fosterer should be seen as a ... and this became very clear to me in our discussions. So, if you do not have the broader workforce in your fostering, all right, underneath the specialist fosterers, what happens is ... say we train up 3 people to become specialist foster carers. If the

foster carer workforce underneath you 3 was not there, you would be full to capacity within quite a relatively short period of time, and the way that effective specialist fostering works is that you would say, take that child, work with them and then pass them, for want of a better word, on to foster carers who were at a slightly different level of work force.

Deputy J.A. Hilton:
So are you just trying to say that you just simply have not got enough foster carers at the moment?

The Deputy of St. Ouen:
From the sound of it, yes.

Mr. A. Heaven:
No, I am not. To start with, we have got around 40 at the moment.

Deputy J.A. Hilton:
But you have not got any specialist foster carers?

Mr. A. Heaven:
Correct. It is a flat structure at the moment and it does not matter what needs that child has.

Deputy J.A. Hilton:
Can you tell me why we have not got any? Is it because there just are not the people available in Jersey to offer that?

Mr. A. Heaven:
This goes back longer than me in terms of why we have not got any, and it just has not developed in the same ways fostering has developed in …

Deputy J.A. Hilton:
Why?

Mr. A. Heaven:
You would have to …

Senator S.C. Ferguson:
Has anybody tried to find out?

Mr. A. Heaven:

I think, listening to people, they have tried to develop it but the investment has not been there.

The Deputy of St. Ouen:

But you have got the investment now?

Deputy J.A. Hilton:

What do you …

Mr. A. Heaven:

Yes, and that is what we are doing.

Deputy J.A. Hilton:

What do you mean the investment is not there? Do you mean financial investment or ...?

Mr. A. Heaven:

Has not been there in the past.

Deputy J.A. Hilton:

Right, but it is there now?

Mr. A. Heaven:

It is and that is what we are …

Deputy J.A. Hilton:

So, what is happening now?

Mr. A. Heaven:

I have just explained, so …

Deputy J.A. Hilton:

No, you have just completely lost me. I am really sorry.

Mr. A. Heaven:

Okay, well which bit did I lose you on?

Deputy J.A. Hilton:

What we are trying to establish is out of the services that were agreed in the *Health White Paper* in 2013-2015 is, where are we with those services? What services have been implemented and if they have not been implemented, why have the not been implemented? Okay?

Mr. A. Heaven:

Yes. Okay. So specialist fostering is into its implementation phase and before it can do any specialist fostering we have to train our workforce up.

Deputy J.A. Hilton:

Okay, so it is in the implementation phase?

Mr. A. Heaven:

Yes.

Deputy J.A. Hilton:

Right, thank you.

Mr. A. Heaven:

No problem.

Deputy J.A. Hilton:

Okay.

The Deputy of St. Ouen:

Can we just ask when you are expecting it to be up and running?

Mr. A. Heaven:

Yes, in the implementation plan that was signed off, it was at 2015.

Senator S.C. Ferguson:

Will it be?

Mr. A. Heaven:

I have been given no indication that that is wrong, so as is.

Senator S.C. Ferguson:

Okay.

Director of System Redesign and Delivery:
It is actually fostering and adoption week this week.

Mr. A. Heaven:
This week.

Deputy J.A. Hilton:
Yes, it is.

Director of System Redesign and Delivery:
Yes, so you will see there is a big awareness campaign running to try to explain to Islanders what it means to foster a child and we are hoping that through that, through a pop-up shop up in Halkett Place and the awareness campaigns, more people will come forward and offer themselves up as foster carers of all different levels. Existing foster carers will also put themselves forward for the additional training and skills that they will need to be the specialist foster carers. Now that we have got the investment there that can recompense them for those additional skills, it is a much more attractive option for people.

Deputy J.A. Hilton:
Yes. I mean, I totally agree with you. I suppose the disappointment for me is that after agreeing the White Paper in October 2012, we are now 18-19 months on from that and we have not moved any further forward with foster services, even though the money has been there, and that is really disappointing because we know the Children's Service comes under a lot of pressure in Jersey. I suppose the reason I was asking you is I wanted to understand why we were not any further forward. I did not know whether it was because the department had not moved it any further forward or whether it was because there simply are not enough people out in our community, because we have such a high percentage of women who work. I did not know whether that was the reason for it, so anyway we will close it there because I have seen about the pop-up shop and everything and that is great. It is just a little bit disappointing to see that really we have not moved on from there. Did you want to say anything?

The Deputy of St. Ouen:
Well, no. We have talked about special fostering, other areas that you have been responsible in delivering?

Mr. A. Heaven:
So, I have got 8 out of 6 that are implemented.

The Deputy of St. Ouen:

8 out of 6?

Mr. A. Heaven:

Yes.

The Deputy of St. Ouen:

8 out of 6? 6 out of 8?

Deputy J.A. Hilton:

6 out of 8, you mean?

Mr. A. Heaven:

Yes, 6 out of 8, you have got me going now. So I can run through them if you want to?

The Deputy of St. Ouen:

Yes, and can we be clear, so just highlighting where you are at ...

Mr. A. Heaven:

Yes.

The Deputy of St. Ouen:

Completed and implemented are 2 different words, are they not?

Mr. A. Heaven:

They are.

The Deputy of St. Ouen:

Implementation is still developing ...

Deputy J.A. Hilton:

Community midwifery. I think that has probably been quite a success story. That has been implemented, has it not, in its entirety?

Mr. A. Heaven:

Yes.

Deputy J.A. Hilton:
That is great. That is really good.

Mr. A. Heaven:
Thank you.

Director of System Redesign and Delivery:
I can give you some interesting figures on that, which I think Andrew probably has as well, but in the first quarter of this year we have had 47 ladies who have come to hospital for their antenatal services, and generally they are the high risk ladies, and 230 have taken advantage of the Community Midwifery Service. So it is offering real choice to ladies there.

Deputy J.A. Hilton:
The community midwives, they are operating out of G.P surgeries, are they not?

Mr. A. Heaven:
Yes, that is right.

Deputy J.A. Hilton:
They are affiliated to … right, okay. Family Care Co-ordinator. Is this a post that is to do with education as well?

Mr. A. Heaven:
No, that comes later.

Deputy J.A. Hilton:
Okay.

Mr. A. Heaven:
No, that is fine. So, your point about completed and implemented being 2 different words. We have got ... as part of the implementation, some of the services are saying: "Well, we will just …" It is the bit about implementation. Do you try and do everything all at once or do you ramp up your service slowly over a period of time, or do you test out some aspects of the service? So, in the Family Care Co-ordination example, what we have done is to second people to those new roles to test out whether they are working, and evaluate them before we go to substantive post. That was the tactic and certainly in the 4 - 6 months that they have had people seconded into that loop, the feedback to come from families has been excellent.

The Deputy of St. Ouen:

But this is what you call a pilot?

Mr. A. Heaven:

You can call it a pilot if you like. I do not like to use that word, but …

The Deputy of St. Ouen:

No. It is used in the document.

Mr. A. Heaven:

The funding is there, all right, for Family Care Co-ordination, so it is not a case of not funding it, but it is testing some of the key principles, because you are trying to work in it in the midst of ...

The Deputy of St. Ouen:

So, when will it be fully tested?

Mr. A. Heaven:

I think they are evaluating it after 6 months and they are looking to recruit substantially to the roles after that. So that is in here.

The Deputy of St. Ouen:

So that is in 2015?

Mr. A. Heaven:

Towards the end of this year, September, I think.

Deputy J.A. Hilton:

That is a really important role because it is working with families with complex needs.

Mr. A. Heaven:

Yes, it is.

Deputy J.A. Hilton:

So, it would have been really nice to have seen that rolled out as well.

Mr. A. Heaven:

But the other bit, Deputy Hilton, is that there is a piece of work that is going on around that, which is around Lean and we are looking ... so back to the piece around seeing it as a system, so you

are not just sticking a person in and hoping they do their best. You are looking at the broader system, so there is a number of pieces of work going on within Children's Development Service and Task, which are looking to make it a much more leaner type of service as well as the investment going in from the White Paper.

Deputy J.A. Hilton:

So can you just confirm, did you say that it was a member of the Children's Service who is currently piloting, an existing member?

Mr. A. Heaven:

I think it is a member of the speech and language team who has been seconded into that role.

Deputy J.A. Hilton:

Okay, thank you very much. Short breaks, respite, presumably that is continuing?

Mr. A. Heaven:

Yes, it is and we are currently supporting 12 families during the pilot period, and that pilot has been running for a period of time now.

The Deputy of St. Ouen:

You are using pilot now.

Mr. A. Heaven:

I am, that is deliberately so. When are looking to have the service funded substantially and have put in place the learning from the pilot from June onwards so we can consolidate that service.

The Deputy of St. Ouen:

So pilot will end in June and the users will be able to look forward to a complete full service, an improved service.

Mr. A. Heaven:

Yes, the reason for running the pilot is you want to make sure you capture the learning, so that is what we have been doing as we have been going through. We now have approved providers. We have looked at and evaluated the pilot and talked to the families involved, and they have given us some clear feedback about what has gone well and what has not. We are looking to weave those into the service going forward.

Deputy J.A. Hilton:

Is this the service that Jersey Autism are a provider?

Mr. A. Heaven:

Jersey Autism are one of the approved providers, yes.

Deputy J.A. Hilton:

Okay, thank you.

The Deputy of St. Ouen:

How will you be communicating the fact to potential users that this improved service will now be available to all?

Mr. A. Heaven:

Okay, so back to kind of systems again. So one of the things that we have been testing in the pilot is somebody's role within ... an existing role has been shaped to accommodate the fact that in the future there will be these services available to families and their role will be to co-ordinate that, and part of that is about communicating effectively to families in terms of their suitability.

The Deputy of St. Ouen:

Just to come back to monitoring outcomes, one of the first outcomes you could monitor is how successful the communication is or has been. Is that your plan?

Mr. A. Heaven:

Communication and being clear about whether one is eligible or not will inevitably be part of any indicator.

The Deputy of St. Ouen:

When are we likely to see outcomes being published?

Mr. A. Heaven:

So it is about to Derek's point about he would like ... we would administer it quarterly but you would want to, again, use the learning from the pilot because we experimented with some outcome measures, and looking at them they are very positive, and so we have got some benchmarks. So we would look to repeat as benchmarks came forward.

The Deputy of St. Ouen:

One last question and it is open all of the Commissioners, it is the issue around value for money, because obviously that could be the key outcome that you want to be able to demonstrate from all these services. How do you plan to do that?

Mr. A. Heaven:

I think if you ask family what value for money means for them, it is about the service being responsive, it is about the service being good quality, something they can rely. If you ask somebody like us we would be talking about activity. If you talk to providers it is quality. So I think there are a variety of different dimensions you can talk to about value for money.

Ms. J. Yelland:

All I would say is whose outcome is it, who wants to know, because there are different outcomes for different things. So if I am someone receiving a service the only thing that matters to me is my life has got better as a result of contact with the state. So that is what I want for me and my family, so that would be an outcome that ... so in system terms we need to be much more systematic about finding out what people's experience of using services is like. So if my life had not got better how can that possibly be value for money? So in terms of ...

The Deputy of St. Ouen:

Sorry, that has to be linked to the additional investment, though, surely?

Ms. J. Yelland:

Just to be Devil's Advocate, we are talking value for money for what? So the totality of the spend that the State puts into health and social care provision, because remember the White Paper investment is a very small percentage of the total picture. So, as a Commissioner, I am interested in understand the value for money for the totality of it, because the investment in the White Paper is pump priming new ways of working to test out if we do things differently will we get better outcomes and better value for money. It is also filling some gaps that have been identified in the services that we did not have in order to do the same thing.

[15:45]

So if you just isolate the White Paper money, and you do not look at the bigger piece, you could be missing the point. You could hit the target and miss the point. So I think we have to look at it in system terms. I think every service needs to have some clear objective measures that look at efficiency, effectiveness, outcomes and customer experience. So we need to build that and that is the work that has gone on in individual contracts. Then the work that we are beginning to think

through at the moment is using all that learning to say: "What are the things across the system that we need to measure so that we know whether the system is delivering value for money?" This is the holy grail. If we achieve this we will be able to sell this globally. It is what everyone is trying to do, but there are some indicators that are used, for example, the rate of unplanned hospital admissions for older people is used as a proxy measure for an efficient system. So if you admit fewer older people to hospital in an emergency because you are able to meet their needs in the community then that is often used as an indicator of a system. Depending on how much you are paying for that system will tell you whether it is value for money.

Senator S.C. Ferguson:

How are you going to fit all this in with the Lean? Because I do not understand why if you are doing system design and analysis, Rachel, why are you not also running the Lean programme?

Director of System Redesign and Delivery:

We are. Health and Social Services was the first States Department to ...

Senator S.C. Ferguson:

Yes, I know but you are not running it.

Director of System Redesign and Delivery:

Do you mean me personally?

Senator S.C. Ferguson:

The Director of H.R. (Human Resources) is running.

Director of System Redesign and Delivery:

Right.

Senator S.C. Ferguson:

Which seems a bit inconsistent. If you are on system analysis and design and obviously, Jo, you are talking really the systems analysis language, so why is it not all being done together?

Director of System Redesign and Delivery:

We work ... the teams work very closely together and, you are right, the Director of H.R. is the S.R.O. (Senior Responsible Officer) for Lean and I am the Deputy S.R.O. The Director of H.R. is the States link for Lean and always has been. So the Lean work stays under his remit but I am the Deputy S.R.O. to that. The team works very, very closely together and, in fact, some of the winter

pressures work, for example, that Jo was leading with Derek, had a very strong Lean redesign right the way through it.

Senator S.C. Ferguson:
So when are we going to see some reports on it?

Director of System Redesign and Delivery:
On Lean or on the winter pressures work?

Senator S.C. Ferguson:
Well, both. If one is part of the other then both.

Director of System Redesign and Delivery:
So the reports have already started to come out on some of the Lean projects we did. So, for example, the hospital dining room.

Senator S.C. Ferguson:
Yes, I know that one but, I mean, the real meaty ones.

The Deputy of St. Ouen:
Sorry, just coming back to looking at the whole system, and I can understand why you have had to do that, but to do that I believe that you told us before you need to have a handle on how much, so the cost, what resource being used and so on an so forth, and you flagged - not just you, Jo, others have as well - the paucity of information available. How are you going to deal with that?

Mr. D. Hoddinott:
Sorry, I can just go into an additional level of granularity, when you talk about outcomes. When you talk about the principles you apply, and in this case in system terms, if you take it down to a more micro level some of the existing services - I will return to pulmonary rehab - we have mentioned that there is a range of different indicators. It does ... from whose perspective you view the data to which is important. So on that particular service we are tracking a number of things. We know how much it costs because we have agreed a price for the service, we have now got activity, how many sessions are run, how many people are being supported through the programme, so we can get down to unit cost associated with that service. We can look at health outcome in terms of the impact on the individual by looking at a number of object measures which are used internationally to evaluate outcomes for individuals. We can look at the impact for that cohort of patients based on what their previous experience was of unscheduled admissions and readmissions into the acute service, and how that has changed. We can then look at the

perception from an individual's point of view of how it has impacted on their health. Again, using established structured and validated tools. Things like European Quality Commission EQ5D for example, which is a set of questions to evaluate from the customer's perspective. Has this made a blind bit of difference on your health from your perspective? So Jo's point: "Has it made a difference to my life?" That covering the health outcome element, the quality of life impact and I do not know if any of you saw the coverage that we had on Channel T.V. (television) on the pulmonary rehab programme. But the example of that, of what that lady was saying there, tracking that in an objective way, that is a huge impact on that lady's life because she can play football in the park with her grandchildren. So tracking that sort of information and in terms of the quality of the experience of being on the programme, which is also important in terms of whether people are going to participate. So at a micro level that gets us to the position ... and all those factors which are described in there enable us to say: "Has that represented value for money for the investment we have made?"

Ms. J. Yelland:

Part of that is ... that is why we spent so much time last year going back having conversations with people about that very thing because value for money can mean different things to different people. So again we need to say: "What do really mean? What are we talking about?" and it is really getting the commonality ... as we move forward into some of the whole system thinking ... you know, we have talked about out of hospital, bringing all of these different initiatives together into one whole system we will be able to identify 3 or 4 strategic measures. So unplanned hospital admissions would be a key one; usage of A. and E. (Accident and Emergency), that kind of thing. So we would have perhaps 3 or 4 system measures and then you would have individual outcome measures, so: "Has my life got better as a result of it?" We have financial measures because we know how much we are spending and then each service you would have service quality standards and measures. So you are building, if you like, a layered approach that has your strategic right down to your detailed: "This service operates like this and we know it is good because of X."

The Deputy of St. Ouen:

That is the sort of information that we will be seeing soon?

Ms. J. Yelland:

I think you will see ... as Derek as described for the pulmonary rehab, there is a not of detail. So what Derek can tell you is that is a good quality value for money initiative and we can tell you that about that system. What we could not tell you yet was how much has that service impacted on the whole piece. That is the bit that is going to take us longer to do.

Senator S.C. Ferguson:

How many of those people have been kept out acute care?

Ms. J. Yelland:

Exactly. So we could probably say one of the things we are looking at at the moment is how we ... as the long-term conditions programme ... so remember the pulmonary rehab is part ... is the first big one to go through. There will be some common criteria that we might use to identify people who could participate and the sort of things that we are thinking about are the number of people who were admitted as an unplanned admission ... sorry, the people who perhaps had more than one unplanned admission in the last 12 months. So let us find out how many of those were there in our system? We can get that information and then we can have a look at why did they go into hospital? How old were they? How many of them had a primary diagnosis of diabetes or ... and we are beginning to start that work now so that we can predict what we think should happen as the pulmonary rehab rolls out, as other work comes around, the cardiac stuff, and then we can start saying that we would expect on that basis to see how the hospital is used next year and the year after to look a bit different. Then we would put that forward and say: "Okay, that is the system measure." We are hoping that we will have some of those to start from January 2015, some high level system measures that we would then be regularly looking at. So month on month we would be getting the information in, what is changing, looking at the trend.

The Deputy of St. Ouen:

How long would you anticipate it taking to create appropriate outcomes, development outcomes, for each of the services that are currently provided under Health and Social Services?

Ms. J. Yelland:

How long does it take to develop the outcome measures? There are so many different outcome measures it is choosing the ones that are intelligent. I think we have this balance between trying to justify so much that we spend a lot of time collecting stuff that does not really tell us very much, and that is where we really have to get to. I think it is really important in the pilot stages to gather as much information as you can, so you have to learn, but what we have to do is to develop, I think, some common outcome measures that we apply across the board.

The Deputy of St. Ouen:

Can you not buy something off the shelf? I mean you are not inventing the wheel.

Ms. J. Yelland:

Yes, you could. There are lots of different approaches and a key part of our learnings, or my learning here is that I think that is really good but there is going to be 20 other people who think

something else is really good. What I have to do is invest my time in everybody showing and telling the thing they think is really good so that we can all agree on one thing that we all think is good. That is one of the things that has taken us a huge amount of time. Some of the work that we do, the soft work, is in getting people to share, show and tell, and then agree: "We will have a system measure and not my favourite measure."

Mr. D. Hoddinott:

Just to reassure in what I have described in relation to pulmonary rehab for other services like Jersey Talking Therapies, for example, there are a range of indicators covering the same thematic areas for those services. Ditto for the Adult Community Mental Health Services. Each service that we are putting in place we have a range of measures ... what Jo is describing is then taking it up a level so you have got the individual components for individual services, which are important, but we can also track as far as the whole system impact because would it be that pulmonary rehab has made the impact on having a reduction in the number of people going in to the hospital on an unscheduled basis or was that service X or Y or Z? What we are interested in is collectively as a system in achieving that but then the component parts of that system, each of the pillars then demonstrating that it is delivering effective outcomes in relation to those individual services.

Ms. J. Yelland:

So to keep up with what we have been doing in the last year with the F.B.C.s (Full Business Cases) is, if you like, bringing some of it up to date. So if you write a business case tomorrow, there will be more research coming up, it will be out of date. So we have taken those and as we have gone through the pilots and the testing we have said the principles still stand because the evidence base is that if you do long-term conditions management it helps people and will deliver good outcomes, but how you do it is changing all the time. The intermediate care piece is a classic example of that, which is why we have changed our thinking and worked with others on Island to help people bring up to date with what is a huge body of evidence. So it is always going to shift and what we write down as a plan is always going to be different in what it finally looks like, because we are learning and I think it is that balance between having the flexibility to do the right thing but not missing the point.

Deputy J.A. Hilton:

Thank you. Just before we leave Children's Service, because there is an important aspect that we have not spoken about, which is under early intervention or sustained home visiting or therapeutic parenting programme, has that service been rolled out?

Mr. A. Heaven:

Sustained home visiting has been signed off and they are in the implementation phase. Part of that is they have had their training and I know that their health visitors are implementing that model.

Deputy J.A. Hilton:

So Family Nursing is rolling that out. You have a service level agreement with Family Nursing, so they are leading on that?

Mr. A. Heaven:

They are leading the implementation of that service.

Deputy J.A. Hilton:

Okay, and just so that I am totally clear, that is a service that is going to run for 2 years for those families who are considered to need that?

Mr. A. Heaven:

That is right.

Deputy J.A. Hilton:

Okay, that is great, thank you. Can we just touch on healthy lifestyles? As with all the others it is a really important one and I know that you are involved in that. Has that service been rolled out?

Mr. A. Heaven:

Yes, and it falls into the categories I was saying to Deputy Reed earlier, which is they want to test the model that has been put forward in the service spec and signed off. So what that looks like is they want to base specialist nurses in general practice, where their G.P. and also the patient has immediate access, so that that assessment and also treatment happens in the primary care setting as opposed to in a Victorian building somewhere in town. So they want to test that and they have identified 2 practices to do that and that is what they are going to be doing in the next 3 or 4 months, so that is really exciting.

Deputy J.A. Hilton:

So that service is going to be delivered by G.P. practices, or in G.P. practices?

Mr. A. Heaven:

In and with.

Deputy J.A. Hilton:

Okay, thank you very much. Anyone have anything else? No? All right, we have run out of time really but we thank you very much for your input this afternoon, it has been really helpful. Okay, I will close the meeting. Thank you.

[16:00]